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Testimony Regarding
S.B. No 220: An Act Concerning the Elimination of Certain Department of Social Services Reporting Requirements
S.B. No. 281: An Act Concerning Public Participation in Meetings of the Pharmaceutical and Therapeutics Committee
H.B. 5056: An Act Implementing the Milliman Report's Recommendations to Achieve Cost Savings in the HUSKY program
H.B. No. 5297: An Act Concerning the State-Wide Expansion of the Primary Care Case Management Pilot Program

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Human Services Committee
March 2, 2010

Senator Doyle, Representative Walker and Members of the Human Services Committee:

I am a senior policy fellow with Connecticut Voices for Children, a research-based public policy think tank that works statewide to promote the well-being of Connecticut's children, youth, and families. I am submitting this written testimony on behalf of CT Voices.

Senate Bill No. 220 would eliminate the Department of Social Services' statutory obligation to report on various programs under its jurisdiction. While it may make sense in some cases to eliminate or reduce reporting requirements where a program is defunct or a mandate has been fulfilled, we suggest that this Committee first determine whether the underlying obligation contained in a statute has been met before considering whether elimination of the reporting requirement is warranted. We therefore have the following comments about three specific sections of S.B. 220:

Maintain the reporting requirement regarding presumptive eligibility for pregnant women until it has been successfully implemented. (Sec. 8)

In 2008, the Department was mandated to implement presumptive eligibility (PE) for pregnant women in accordance with the federal definition of PE under Medicaid. PE allows certain health care providers to make an initial eligibility determination and therefore allows pregnant women to obtain coverage quickly. This is no time to eliminate the reporting requirement set forth in paragraph (e) since the Department has yet to fulfill this statutory mandate. Department personnel recently stated that presumptive eligibility will be implemented this month (March 2010). Presumably, the biannual reporting requirement in paragraph (e) is being eliminated because the Governor has proposed to eliminate the Medicaid Managed Care Council in another bill, and the report required by this section is to be sent to the Council. As we and others testified last week before this Committee, we oppose the elimination of the Council whether or not Medicaid managed care is converted to an administrative services organization. The Council provides an important public forum for discussion of the financing, coverage and access issues related to the HUSKY program which serves about 380,000 children, pregnant women and parents, and an advisory council is required by federal law. See 42 CFR Sec. 431.12 (requiring a medical care advisory committee). In any event, this committee and the Council should be monitoring the implementation of PE for pregnant women. It is good public policy and it is mandated by this statute.

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Smoking cessation as a Medicaid-covered service was never implemented. (Sec. 9)
The bill would delete language that references a Department of Social Services plan that was developed to provide smoking cessation services in Medicaid and presented to the Human Services and Appropriations Committees in 2004. While the Department has fulfilled its reporting obligation under this statute, we take this opportunity to point out that the legislature never appropriated the funds to include smoking cessation as a Medicaid benefit and the Department never amended the Medicaid state plan to include such covered services. As a result, nicotine replacement and medications to treat smoking cessation are not covered under Connecticut's Medicaid program – giving Connecticut the dubious distinction of being one of only a handful of states that persist in not covering tobacco cessation products and services.

As we stated in our testimony before the Appropriations Committee regarding disbursement of funds from the Tobacco and Health Trust Fund on March 12, 2008.[1]

> "The Connecticut's Department of Social Services estimated the cost of providing smoking cessation treatment for the entire Medicaid population, including the elderly and disabled, would range between $3.8 million to $9.5 million. Four years later, Section 19 of Public Act 02-04 remains unfunded. Connecticut is missing out on a crucial opportunity to draw down funds from the federal government. For every dollar Connecticut invests in smoking cessation through Medicaid, the federal government will reimburse the state 50 cents to match our investment.[2]
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> Despite its clear cost effectiveness and a federal directive issued in 2001 by the Centers for Medicare and Medicaid Services to cover children and pregnant women, Connecticut lags behind the rest of the nation in providing smoking cessation programs for its Medicaid population. **In 2006, Connecticut was one of only five states whose Medicaid program did not cover any tobacco dependence treatments recommended by the Centers of Disease Control.**" (emphasis added)

We again encourage the legislature to mandate coverage for smoking cessation in the Medicaid program.

The Departments of Social Services, Public Health and Children and Families have not implemented a "child health quality improvement program". (Sec. 11)

As far as we know, the Department of Social Services in collaboration with DPH and DCF has not implemented the child health quality improvement program for HUSKY, required by this statute. Presumably, if this effort were under way the Department alone or in conjunction with its agency partners would have discussed it at the Medicaid Managed Care Council which advises the Department about the HUSKY program. Thus, if we are correct that no such coordinated quality improvement program is in place, the question for this legislative body is whether the underlying mandate of this section should be fulfilled before repealing the reporting requirement contained in paragraph (b). We certainly support the goals of this legislation but we are unsure whether the Departments currently have the resources to fulfill this statutory mandate.

We support S.B. 281 which would allow members of the public to express their views at a meeting of the Pharmaceutical and Therapeutics Committee. An opportunity for public comment seems reasonable and is consistent with an open government. The P&T Committee advises the Department of Social Services regarding drugs that are included on the "preferred drug list" for the state's pharmacy program which serves over 500,000 residents receiving health coverage through HUSKY, Medicaid, SAGA or the Charter Oak Health Plan. Changes continue to be proposed concerning prior authorization of mental health drugs, for example, and concerns that such a mechanism will prevent patients with serious mental illness will not receive timely and appropriate medications. Allowing public comment at the P&T Committee meetings would facilitate better communication between the decision makers and the public.

H.B. 5056 would require the state to "recover fifty million dollars in over payments from [HUSKY] managed care organizations . . . and implement primary care case management state wide. . ." . We take this opportunity to reiterate our support for the Governor's proposal to convert HUSKY risk-based managed care to a non-risk administrative services organization model. The Governor's budget assumes a budgetary savings of $50 million – based on the state Comptroller's audit (i.e., the "Milliman Report" referenced in this bill). In addition, we urge utilization of an ASO in combination with primary care case management (PCCM) and support permitting children in HUSKY B the opportunity to participate in PCCM as an alternative to risk-based managed care plans – assuming the health plans remain in place. Finally, we would also support the transparency and accountability provisions in the bill, e.g., conducting an annual audit of the program.

H.B. 5297 would require the Department of Social Services to expand the primary care case management pilot state-wide by October 1, 2010. We would add to this requirement that PCCM be supported by an administrative services organization for certain functions that primary care providers may find challenging to implement. Under federal and state Medicaid guarantees of "early and periodic screening, diagnostic and treatment" (EPSDT) services, primary care providers – particularly those in smaller practices – may find it difficult to arrange all of the EPSDT mandated services, such as transportation. An ASO can help facilitate such arrangements, as well as provide other back office functions for PCPs.

Thank you for this opportunity to submit testimony concerning the above mentioned bills. If you have any questions or need additional information, please contact me.

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[1] Testimony Supporting H.B. 5020: An Act Implementing the Governor's Recommendations regarding the Tobacco and Health Trust Fund, T. Ali & S. Langer, M.Ed., J.D. (Mar. 12, 2008), available at www.ctkidslink.org/testimony_archive.html

[2] If Connecticut had instituted smoking cessation, it would be receiving almost 62 cents on the dollar from the federal government for Medicaid covered services under the stimulus package, from October 1, 2008 through December 31, 2010 – and most likely beyond 2010 - since the expectation is that Congress will authorize continuation of the increase in federal Medicaid matching funds.